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Research on Religious Variables in Five Major Adolescent Research Journals: 1992 to 1996.

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A review of quantitative research studies published between 1992 and 1996 in five major adolescent journals revealed that 11.8% (109 of 922) included a measure of religion. This percentage (11.8%) is 3 to 10 times higher than that found in previous reviews of empirical research in psychological and psychiatric journals, suggesting that adolescent research journals are more sensitive to the role of religious factors on mental health than research in related disciplines. The results are discussed in the context and philosophy of the adolescent research and in comparison with related disciplines.

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Americans are a religious people. About 40% of Americans worship at a church, synagogue, mosque, or temple weekly, and about 60% attend monthly (Gallup, 1996). More than 90% of Americans want some form of religious education for their children (Hoge, 1996). Ninety percent of Americans consider religion "very important or fairly important" in their lives (Gallup, 1996).

Based on the findings of a 1992 national survey by the Gallup Poll, this will continue to be the case for the next generation. Large numbers of American teenagers believe in God (95%), pray alone frequently (42%), read scriptures weekly (36%), belong to a religion-sponsored youth group, or attend worship services weekly (45%). In a somewhat surprising finding, 27% of teens consider religious faith more important to them than it is to their parents and report being slightly more likely to attend worship services than adults (Gallup and Bezilla, 1992).

Studies indicate that religious involvement has many positive social benefits. Youth who practice their faith have increases in prosocial values and caring behaviors. Among the 3 teens in 4 who are members of a religious group, 62% are community volunteers and 56% make charitable contributions. Among those who have no religious affiliation, only 44% are volunteers and 25% are contributors (Gallup and Bezilla, 1992). Other researchers have found that the importance of religion in one's life and worship attendance are associated with a greater concern for the poor and more frequent helping behaviors (Benson et al., 1987).

Religious involvement can help teens reduce "at risk" behaviors, like alcohol and drug use, delinquent behavior, premature sexual involvement, unsafe sexual behaviors, and suicide (Donahue and Benson, 1995)—many of the negative behaviors about which adolescents express the greatest concern. When teens are asked to name the biggest problems facing people in their age group, drug and alcohol use account for about half the responses (47%), followed by peer pressure (15%), AIDS (11%), teen-age pregnancy (9%), sex (6%), crime or teen gangs (6%), and school problems (5%). It is interesting to note that only 2% of the teens indicated that getting along with their parents was their biggest problem (Gallup and Bezilla, 1992).

Clergy are a primary mental health resource for American families. In 13 separate studies representing a diverse group of urban and rural clergy between 1979 and 1992, it was found that those who seek pastoral counsel bring problems predominantly related to marriage, family, and parenting issues (Weaver et al., 1997). Wasman et al. (1979) report that 85% of parish-based clergy indicated that family problems were the most frequent and difficult counseling issues they were asked to address—especially noted were marital conflict and problems with adolescent children. In a survey of 405 pastors in 10 geographic regions of the United States, Benner (1992) found that 84% of the clergy identi-

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This article is dedicated to Archbishop Oscar Arnulfo Romero of El Salvador who dared to call for peace and justice in his tortured land. He was murdered while offering Mass on March 24, 1980. We wish to express gratitude to Lisa Matsumoto and Chris DeGray for their generous help during the development of this project.

fied marriage and divorce as the most frequently presented problems, and about 1 in 3 of the pastoral counseling sessions involved problems with children. Although teenagers report holding high regard for clergy, and more than 8 of 10 teens give clergy high marks for service to the community, in contrast to their parents, they are unlikely to seek clergy help with personal problems (Gallup and Bezilla, 1992).

Religious involvement is particularly important to many ethnic minority communities, such as African-Americans. In a study of 637 black churches in the northern United States, two-thirds offered some type of family-oriented community outreach program, although only about one-fourth of the churches had programs directed toward adolescents (Rubin et al., 1994). The mental and physical health benefits of non-punitive religious practices and beliefs for African-Americans (Levin et al., 1995), Hispanic-Americans (Levin et al., 1996), and Asian-Americans (Holtz, 1998) have been documented across the life span.

Given the high interest in religion among adolescents, the use of religious community and clergy by American families, and the study of religious coping among ethnic minorities found in several disciplines, the authors decided to assess the current level of quantitative research on religion in adolescent journals.

Methods

The data for this study consists of empirical articles in all issues of five major adolescent research journals published between 1992 and 1996: a) *Adolescence*, b) *Journal of Youth and Adolescence*, c) *Journal of Adolescence Research*, d) *Youth and Society*, and e) *Journal of Adolescence*. Each article was reviewed to determine whether it contained either descriptive or inferential statistics evaluating an aspect of religion. Empirical articles were defined as studies including a methods and results section with the use of at least descriptive statistics. Excluded from consideration were opinion pieces, commentaries, rejoinders, and letters to the editor. To identify studies that fit these criteria, the authors systematically reviewed titles, abstracts, methods sections, results, tables, and charts in all volumes over the 5-year period. Articles that considered any form of religion were read in detail and coded by content. To ensure reliability of the review, randomly selected articles from each journal were evaluated by two trained reviewers and coded separately. Overall interrater agreement was 96%.

The articles were appraised for content in a method similar to that used to study psychology (Weaver et al., 1998b), psychiatry (Larson et al., 1986; Weaver et al., 1998c), mental health nursing (Weaver et al., 1998a), gerontology (Sherrill et al., 1993), and family medicine (Craigie et al., 1988). The authors identified each of the religious measures in every article and counted the number of religious variables measured in each article. A religious variable was considered to be any identified empirical measure of a religious concept or behavior. The complexity of the experimental design was also addressed in terms of the number of other types of variables included in the design (*e.g.*, gender, age, etc.). In addition, the authors reviewed and tabulated all citations referring to previously published religious research to assess the utilization of research on religion.

Results

Over 5 years, the five journals published a total of 922 quantitative studies that included at least a single descriptive statistic used in the methods and results section of the article. Of the 922 quantitative articles, 109 (11.8%) included and assessed a religious variable. The percentage for the individual journals are given in Table 1.

As seen in Table 2, the aggregate figure of 11.8% is much higher than that found in psychiatry (Larson et al., 1986; Weaver et al., 1998c), family medicine (Craigie et al., 1988), gerontology (Sherrill et al., 1993), or psychology (Weaver et al., 1998b) and somewhat higher than mental health nursing journals (Weaver, et al., 1998a). Indeed, the percent of quantitative studies in adolescent journals that measured at least one religious variable was roughly 3 to 10 times higher than had been found in other relevant clinical disciplines.

Current standards of research on religion suggest that the measurement of religion requires the use of multidimensional methods and that using only a single variable may provide insufficient information (Larson et al., 1986). Religious affiliation, for example, may simply provide a measure similar to ethnic background, rather than actual religious involvement (Larson et al., 1989). Because multidimensionality could be considered an indicator of sound research methods, the authors measured the number of religious questions addressed in each article assessing how frequently religious measures such as affiliation, practice, or beliefs were included. The authors found that 47 of the 109 articles (43%) used two or more questions to assess the religious variable, whereas 62 of 109 (57%) used a single item. The 43% of adolescent articles using two or more questions was similar to the 39% found in mental

TABLE 1
Number and Percentage of Quantitative Articles Containing a Religious Variable in Five Adolescent Journals between 1992 and 1996

Journal names	No. quantitative articles	No. with a religious variable	Percentage with a religious variable
Adolescence	380	33	8.7
Journal of Adolescence	151	14	9.3
Journal of Adolescence Research	102	15	14.7
Journal of Youth and Adolescence	184	19	10.3
Youth and Society	105	28	26.7
Totals	922	109	11.8

TABLE 2
Percentage of Quantitative Studies Containing Religious Variables in Different Disciplines

Discipline examined	Percentage containing a religious variable	Years
Family medicine	3.5	1976–1986
Psychiatry	2.5	1978–1982
Gerontology	3.6	1985–1991
Psychology	2.7	1991–1994
Psychiatry	1.2	1991–1995
Mental health nursing	10.0	1991–1995
Adolescence	11.8	1992–1996

health nursing (Weaver et al., 1998a). It was greater than the 18% found in gerontology (Sherrill et al., 1993), the 21% in psychology (Weaver et al., 1998b), or the two psychiatry reviews, 17% in Larson et al. (1986) and 22% in Weaver et al. (1998c), suggesting that adolescent studies tend to have better methodological designs when considering the religious factor.

As a rough assessment of the degree to which the literature reviewed here on adolescents tapped the broader literature on religion, the authors tabulated the number of references to other published religious research found in adolescent journal articles. It was discovered that 70 of the 109 studies (64%) that analyzed a religious variable cited previously published religious research. This was a much higher percentage than was found in either gerontology (18%) in Sherrill et al. (1993), mental health nursing (26%) in Weaver et al. (1998a), psychology (27%) in Weaver et al. (1998b) or two studies in psychiatry, 14% in Larson et al. (1986) and 22% in Weaver et al. (1998c).

Discussion

This systematic review of the published research concerning the frequency and quality of the study of religion pertaining to various aspects of adolescent mental health, as represented by five major journals in the field, reveals several research strengths in this discipline when compared with other clinical research domains. First, when compared with previously reviewed disciplines, including psychology, psychiatry, geriatrics, and family medicine, the frequency of including at least a single measure of religion was about 3 to 10 times greater. There was a slightly larger percentage of articles using a religious variable in this sample than was found in mental health nursing journals. Unlike several other fields, the researchers on adolescence made greater use of the published research on religious factors as well as multiple measures of them. Use of multiple measures increases the likelihood of providing the quality of information that researchers are seeking (Gartner, 1996). There are many well-designed studies in this review of research in adolescent journals that add substantially to the literature.

This look at the inclusion of religious variables in adolescent research journals leads naturally to a consideration of what they have to say about salient mental health or mental health-related issues affecting adolescents. These issues include suicide, sexuality, posttraumatic stress, access and utilization of formal and informal mental health services, unconventional belief systems (Satanism), substance abuse, and anti-social behaviors. In each case, we can see the contribution of religious factors to the explanatory process, even given the limited scope of existing research published in adolescent journals.

Suicide

In the United States, one in seven deaths among those 15 to 19 years of age is a suicide. For 15- to 19-year-olds, the rate of suicide in 1950 was only 2.7 per 100,000. Two generations later the rate had risen to 11.1, in 1990 an increase of more than 400% (National Center for Health Statistics, 1993). One notable discovery in the adolescent journals was four articles that considered the role of religion among individuals at risk for suicide.

In a study of 525 Israeli adolescents, researchers examined the relationship between their attitudes toward suicide, psychosocial background, and suicidal tendencies (Stein et al., 1992). Of the demographic and psychosocial variables evaluated, gender, religious involvement, and previous exposure to suicide were found to be significantly associated with negative attitudes toward suicide. Increased risk was associated with a positive attitude toward suicide. This study is one of several providing evidence that religious involvement pro-

tects some young people against suicidal ideation and behavior.

Adolescent suicide has been linked to depression (Birmaher et al., 1996). One study in the sample found that frequent church attenders in Texas with high spiritual support had the lowest scores on the Beck Depression Inventory. Those high school students of either gender who were infrequent church attenders with low spiritual support had the highest rates of depression, and these rates were often found to be at clinically significant levels (Wright et al., 1992).

Previous studies have shown that the risk of taking one's life is lowered for frequent church attendees across the life span (Lester, 1991; Weaver and Koenig, 1996), particularly among ethnic minority groups such as African-Americans (Needleman et al., 1998). Unfortunately, this research is often ignored or even devalued. For example, scholars evaluating suicide assessment instruments recently observed that "although religion is noted as a highly relevant factor in suicide literature, the number of religious items included on suicide assessment scales approaches zero" (Koehoe and Gutheil, 1994, p. 366).

Sexuality

Several negative consequences have been linked with adolescent sexual activity and teen pregnancy. Early sexual intercourse subsequently predisposes youth to a large number of partners as well as sexual partners older than themselves (Koyle et al., 1989). Sexually active teens are more likely to be involved in delinquent behavior and to use drugs and alcohol (Elliott and Morse, 1989). Teenage parents are more likely to drop out of school, creating long-term educational and economic disadvantages for themselves (White and DeBlassie, 1992).

Thirty-four of the 109 articles in this sample of journal articles measuring a religious factor addressed adolescent sexual issues, such as the timing of sexual intercourse, attitudes toward casual sex, and pregnancy resolution decision-making. For example, among a group of 324 older adolescents in a university setting, moral concerns were a significant predictor of casual sex attitudes. Adolescents who were more religious tended to have more negative attitudes toward casual sex than those who were less religious (Levinson et al., 1995). In a second study, the religious involvement of college students and their families of origin was linked to delayed sexual intercourse in four separate surveys over a period of 17 years from 1974 to 1991 (Murstein and Mercy, 1994).

In a third study, a researcher used data from a national survey of unmarried African-American adolescent female responders 15 to 21 years of age of middle-class status. She found that high religious involvement was strongly correlated with delayed first sexual intercourse. Frequent church attendance proved to be the second strongest predictor of sexual timing among eight variables tested. Only the level of sexual knowledge proved to be a stronger predictor. Other predictors measured included contraceptive knowledge, parents' communication about contraception and sexually transmitted diseases, and family structure (Murry, 1996). These findings support the hypothesis that the black church may provide meaning, social support, and norms for sexual conduct that delay the first sexual intercourse among middle-class African-American youth.

A fourth study in the sample addressed pregnancy resolution decision-making among adolescent females. Using data from a national survey, the study sought to identify factors that influenced pregnancy resolution decisions for African-American and Hispanic-American adolescents aged 15 to 21. A hierarchical discriminant function analysis was used. It found that African-American and Hispanic-American female subjects who decided to terminate a pregnancy were more likely to report a religious affiliation and attend church than were those who decided to carry their pregnancy to full term (Murry, 1995).

Research has frequently shown the constraining effects of religious involvement on premature sexual behavior among adolescents. It has been estimated that adolescents involved in religious life may be 50% less likely to engage in sexual intercourse than their non-religious peers (Spilka et al., 1985). However, at least one study found that sexually active church-going teenage girls are less likely to use contraceptives than non-church attendees, presenting greater risk of unsafe sexual behavior and pregnancy (Studer and Thornton, 1987).

Posttraumatic Stress

Only one article in our sample looked at psychological trauma and religious coping. Using factor analysis, the article found that Jewish teenagers in Israel facing the threat of missile attack during the 1992 Persian Gulf war used religion and prayer to positively cope with traumatic stress (Zeidner, 1993). Unfortunately, despite research evidence that most surveyed posttraumatic stress survivors (Green et al., 1988; Weinrich et al., 1990) use religion as a primary coping strategy, such research is rare

in adult and adolescent populations. When researchers have tested the religious factor among trauma survivors, they have found that greater religious participation was related to increased perception of social support, increased meaning found in loss, enhanced well-being, lower distress, and faster and more effective cognitive restructuring (McIntosh et al., 1993).

It should be noted that exposure to violence among children and adolescents in the United States is at near epidemic levels. Homicide is the third leading cause of death among youth under the age of 21 (National Center for Health Statistics, 1993). In an inner-city population of primarily African-American children and adolescents (ages 7 to 18), researchers found an alarmingly high 85% had witnessed and 7 of 10 had been victims of a violent act. Not surprisingly, almost 1 in 3 of the inner city children were found to be suffering from the symptoms of severe psychological trauma similar to those found in combat veterans (Fitzpatrick and Boldizar, 1993). Given studies such as these, we need to understand the effects of psychological trauma on adolescents from exposure to violence and how religion and other coping strategies may or may not be helpful.

Clergy

According to the United States Department of Labor (1998), there are approximately 353,000 Jewish and Christian clergy serving congregations in the United States (4,000 rabbis, 49,000 Catholic priests, and 300,000 Protestant ministers). This estimate does not take into account the nearly 100,000 Roman Catholic nuns (Ebaugh, 1993) or clergy from other religious traditions (*e.g.*, Buddhism, Hinduism, and Islam) in the United States.

The National Institute of Mental Health Epidemiological Catchment Area Surveys found that clergy are more likely than psychologists and psychiatrists combined to have a person with a DSM-III-R mental health diagnosis see them for assistance (Hohmann and Larson, 1993) and many of the problems brought to them involve families with adolescents (Weaver et al., 1999). This frequent use of clergy by the public should not be a surprise, given clergy's availability and accessibility, and the high trust that Americans have in clergy (Weaver, 1995). Young adults rank clergy higher in interpersonal skills, including warmth, caring, stability, and professionalism, than either psychologists or psychiatrists (Schindler et al., 1987).

In a review of 2,468 quantitative articles in eight major American Psychological Association journals from 1991 to 1994, it was found that one in 600 included and assessed the role of clergy in mental health (Weaver et al., 1997). In the sample of 922 adolescent journal articles, five studies examined the role or use of clergy. One study evaluated clergy as potential helpers among college students over a 13-year period. The students were as likely to seek a minister, priest, or rabbi for help as a psychologist or psychiatrist (Rule and Gandy, 1994). A second study examined community services of 635 black churches in the northeastern United States. It found that African-American churches with younger, paid, seminary-trained clergy had more programs for youth (Rubin et al., 1994). A third study found that black, white, and Hispanic pregnant adolescents were less likely to seek the counsel of clergy, therapists, or health professionals for emotional support when compared to friends and family (Koniak-Griffin et al., 1993). These few studies reveal the need for more research to take a closer look at who, why, how, and when young people turn to clergy for help.

Satanism

One of the most interesting areas of study addressed in our sample of adolescent journal articles is the area of unconventional belief systems among youth. Two empirical articles addressed the area of the occult and Satanism. One study examined the etiology of Satanism among 890 juvenile offenders in Texas (Damphousse and Crouch, 1992). Seventy-five or (8.4%) of the adolescent offenders reported some level of involvement in Satanism. In a carefully designed study using a regression analysis model, the researchers found that Satanists had low attachment to conventional society (represented by parents and school) and were highly attached to peers. Having higher intelligence and a sense of limited control of one's life were predictive of Satanic involvement. Caucasians were much more likely to be involved in Satanism than were African-American or Hispanic youth and, somewhat surprisingly, female adolescents were as likely to be involved as male adolescents.

A second study examined differences in psychopathology and behavior disturbances among adolescent psychiatric patients (Burket et al., 1994). It found that 10 of 157 adolescent patients had interest in the occult and Satanism. Those teens interested in the occult were more prone to alcohol abuse, hallucinogen abuse, and self-mutilation than those patients not interested in the occult. There were no significant differences in criminal behaviors between those with and without occult interest.

In a more theoretical article, scholars discussed the possible relationship between abusive, rigid, conventional religious belief systems in families of origin, and Satanic cult appeal among male youth (Belitz and Schacht, 1992). The theories are compelling and deserve testing. Unfortunately, empirical study of unconventional belief systems or of punitive, non-nurturing conventional religion are rare. A full scientific examination of the instances in which religion may have deleterious effects on mental health is needed (Pargament, 1997; Sheehan and Kroll, 1990).

Substance Abuse and Anti-Social Behaviors

Fourteen studies in this sample of adolescent articles focused on teen substance abuse and other anti-social behaviors. The findings were mixed. In a sample of 322 adolescents from a state in the western United States, researchers using a LISREL statistical model found data suggesting that the importance of religion had little influence on teen drug use. The sample consisted primarily of adolescents who had been arrested or admitted to a drug treatment program (Bahr et al., 1993).

In a second study, the author used a statistical path analysis to examine high school and college students. Religious involvement and conservative religious beliefs were negatively, but moderately, related to minor delinquency and illicit substance use. The strongest negative relationship was between alcohol use and religious influence at −.22 (Free, 1993).

A third study used data from a national sample of 1917 male and 1834 female adolescents who were 15 to 17 years of age. It found that with the one exception of personal violence by male adolescents, there was an inverse relationship between frequency of religious attendance and involvement in four problem areas: suspension/expulsion from school, theft, violence, and drug use. Girls who attended religious services occasionally were 1.37 times more likely to use drugs than frequent worshippers (Ketterlinus et al., 1992).

A fourth study in the sample of adolescent studies compared 112 different communities as experienced by 33,397 high school students using the community as the primary unit of analysis. A community was defined as healthier if its high school youth engaged in fewer problem behaviors and less healthy if they engaged in more problem behaviors. It measured 16 problem behaviors in seven areas: tobacco use, alcohol use, illicit drug use, sexual activity, depression and suicide, anti-social behaviors, and school problems.

Analysis revealed that the number of youth involved in structured activities or connected to religious institutions was strongly related to community health. Religious involvement was greatest in the healthiest communities and lowest in the least healthy ones. Communities with a majority of high school students attending religious services at least once a month were twice as likely to be among the communities with the fewest problem behaviors among youth (Blyth and Leffert, 1995).

Previous research provides solid evidence to support the case that religious practice and strength of religion in the family are inversely associated with anti-social behavior in teens (Evans et al., 1996) and fewer drug and alcohol problems (Armoateng and Bahr, 1986; Barrett et al., 1988). In a recent national study, relgious involvement among youth was associated with less likelihood of trouble with the police, fighting, vandalism, gang-violence, physically hurting someone, and use of a weapon to steal (Donahue and Benson, 1995).

Why Does Adolescent Research Tend to Consider the Religious Factor?

What might account for the higher rates of research that consider a religious variable in adolescent research journals when compared to psychology and psychiatry journals? One reason may be that several of the journals we reviewed explicitly state that they utilize a multidisciplinary, human ecological approach to understanding adolescents that incorporates individual, environmental, and social system factors.

In this sample of adolescent journal articles were found a diversity of researchers in 23 areas of study: sociology, marriage and family therapy, psychology, psychiatry, social work, education, public health, nursing, applied human ecology, criminal justice, child development, family studies, humanities, obstetrics and gynecology, rehabilitation counseling, clinical pediatrics, public health, health promotion, political science, anthropology, religious education, Christian ministry, and journalism. This ecological approach provides a comprehensive and integrated understanding of adolescent behavior that seems more likely to consider the psychosocial variable of religion than is the single discipline perspective. Psychology (Weaver et al., 1998b) and psychiatry (Weaver et al., 1998c) journals seem to be limited in their focus by the single discipline approach and are 3 to 10 times less likely to consider the religious variable than are adolescent journals.

In addition, it has been shown that psychologists and psychiatrists are less likely to have religious in-

volvement or clinical training in religious issues (Sansone et al., 1990; Shafranske and Malony, 1990) than other mental health specialists represented in the adolescent research journals. When the general public was asked to respond to the statement, "My whole approach to life is based on my religion," 72% agreed. When mental health specialists were asked to respond to the same statement, 33% of the psychologists agreed, 39% of the psychiatrists agreed, 46% of the social workers agreed, and a substantial 62% of the marriage and family therapists agreed (Bergin and Jensen, 1990). In a survey of academic faculty, 5 of 10 psychologists reported having no religious preference ("Politics," 1991), a proportion about seven times greater than that found in the American population as a whole (Gallup, 1996). By contrast, just 9% of social work and 12% of nursing faculty indicated no religious affiliation ("Politics," 1991). These figures suggest that it is much more likely, for example, that academic social work and nursing faculty publishing research and responsible for training students in research have an awareness of the religious variable and its relevance to empirical studies than psychologists.

Another reason that adolescent research may consider religious variables more often than other mental heath research areas is that many of the key issues in adolescent research are related to impulse control problems where religion has been linked to clinical benefit (Weaver et al., 1999). Gartner and colleagues did an extensive review of about 200 empirical studies on the relationship between religious commitment and psychopathology (Gartner, 1996). Their findings suggest that traditional forms of religion can provide a socially reinforced structure which offers protection from mental heath problems that involve impulse control issues. In this sample of 109 adolescent articles that include religious variables, almost half (52, or 48%) examine problems involving impulse control issues: substance abuse (9), sexual behavior (34), suicide (4), and anti-social behaviors (5). It may be that adolescent researchers have recognized for a longer time than scholars in other research areas that religion is an important consideration because of its value in providing support and structure for youth and their families.

Recommendations

1. More research is needed to investigate the function of religion as a coping strategy for adolescents in distress and their families. How do family members with impulse control and other psychological problems benefit from religious coping? What are the psychological mechanisms of healthy and unhealthy religious coping? Do some forms of religious practice contribute to emotional problems and family dysfunction? If so, what are they? When religious participation is linked to overcontrol, rigidity and authoritarianism, what are the negative mental heath effects? If religious involvement has a buffering effect for some family systems under stress, lowering the risk of distress or enhancing a more rapid recovery, how do these religious coping mechanisms effectively (or ineffectively) operate?

2. There is a need for the inclusion of religious variables in outcome studies of mental health interventions, as well as in epidemiological studies that examine the predictors and course of adolescent mental health problems over time. Such research is needed to better understand what role religion can play in the prevention, onset, status, care, and resolution of mental illness and its clinical consequences, so that clinicians can better address how, when, and why religious issues can benefit or worsen adolescent mental health care.

3. Research is needed to better understand the role of clergy as counselors to teens and their families. How much do clergy know about adolescent mental health issues? How much training in either seminary or post-seminary continuing education do clergy have (and need) concerning adolescent family issues? How often do clergy refer people to child and adolescent specialists and for what situations? How often do clergy have child and adolescent specialists refer families to them for spiritual care? What spiritual resources for clinical care are utilized by clergy when working with distressed teens and their families? What personal and professional characteristics predict whether mental health specialists view clergy as potential allies and collaborators, as being in competition, or as playing a harmful role in this area? Such research may begin to identify barriers that prevent adolescent specialists and clergy from working more optimally together in helping families.

4. Given the scope of research being reported in adolescent journals that incorporates religious factors and issues, it might be worthwhile to compile a basic list of the most clinically relevant religious factors that adolescent researchers should measure. This could be accomplished, in part, by holding symposia on the relationship between religion and health at annual professional meetings. The religious variables should, of course, emphasize the "real-life" behavioral events that are directly observable, precisely measured, and have been shown to be valid (Gartner, 1996). Adherence to rigorous scientific approaches is essential to overcoming any

stigma about religious research (Larson et al., 1998). Finally, the applicability of existing theoretical frameworks on the relationship between religious commitment and mental health (Pargament, 1997) to adolescent research could be considered at research symposia or other forums. As more professionals working with youth realize the significant influence that religion plays in prevention and treatment, one can expect to see an increase in both the quantity and quality of published studies on the topic.

References

Armoateng AY, Bahr SJ (1986). Religion, family and adolescent drug use. *Sociol Perspect* 29:53–76.

Bahr SJ, Hawk RD, Wang G (1993) Family and religious influences on adolescent substance abuse. *Youth and Society* 24:443–465.

Barrett ME, Simpson DD, Lehman WEK (1988) Behavioral changes of adolescents in drug abuse intervention programs. *J Clin Psychol* 44:461–473.

Belitz J, Schacht A (1992) Satanism as a response to abuse. *Adolescence* 27:855–872.

Benner DG (1992) *Strategic pastoral counseling.* Grand Rapids, MI: Baker Press.

Benson PL, Williams D, Johnson A (1987) *The Quicksilver years.* San Francisco: Harper and Row.

Bergin AE, Jensen JP (1990) Religiosity of psychotherapist. *Psychotherapy* 27:3–6.

Birmaher B, Ryan ND, Williamson DE, Brent DA, Kaufman J, Dahl RE, Perel J, Nelson B (1996) Childhood and adolescent depression. *J Am Acad Child Adolesc Psychiatry* 35:1427–1439.

Blyth DA, Leffert N (1995) Communities as contexts for adolescent development. *J Adolesc Res* 10:64–87.

Burket RC, Myers, WC, Lyles WB, Carrera F (1994) Emotional and behavioral disturbances in adolescents involved in witchcraft and Satanism. *J Adolesc* 17:41–52.

Cragie FC, Liu IY, Larson DB, Lyons JS (1988) A systematic analysis of religion variables in *The Journal of Family Practice*, 1976 to 1986. *J Fam Pract* 27:509–513.

Damphousse KR, Crouch BM (1992) Did the devil make them do it? *Youth and Society* 24:204–227.

Donahue MJ, Benson PL (1995) Religion and the well-being of adolescents. *J Soc Issues* 51:145–160.

Ebaugh HR (1993) The growth and decline of Catholic religious orders of women worldwide. *J Sci Study Relig* 32:68–73.

Elliott DS, Morse BJ (1989). Delinquency and drug use as risk factors in teenage sexual activity. *Youth and Society* 21:32–57.

Evans TD, Cullen FT, Burton VS, Dunaway RG, Payne GL, Kethineni SR (1996) Religion, social bonds, and delinquency. *Deviant Behav* 17:43–70.

Fitzpatrick KM, Boldizar JP (1993) The prevalence and consequences of exposure to violence among African American youth. *J Am Acad Child Adolescent Psychiatry* 32:424–430.

Free MD (1993) Stages of drug use: A social control perspective. *Youth and Society* 25:251–271.

Gallup GH (1996) *Religion in America: 1996.* Princeton, NJ: The Gallup Organization, Inc.

Gallup GH, Bezilla R (1992) *The religious life of young Americans.* Princeton, NJ: The George Gallup International Institute.

Gartner JD (1996) Religious commitment, mental health, prosocial behavior. In EP Shafranske (Ed), *Religion and the clinical practice of psychology* (pp 187–214). Washington, DC: American Psychological Association.

Green BL, Lindy JD, Grace MC (1988) Long-term coping with combat stress. *J Traum Stress* 1:399–412.

Hoge DR (1996) Religion in America. In EP Shafranske (Ed), *Religion and the clinical practice of psychology* (pp 21–41), Washington, DC: American Psychological Association.

Hohmann AA, Larson DB (1993) Psychiatric factors predicting use of clergy. In EL Worthington Jr. (Ed), *Psychotherapy and religious values* (pp 71–84). Grand Rapids, MI: Baker Book House.

Holtz TH (1998) Refugee trauma versus torture trauma: A retrospective controlled cohort study of Tibetan refugees. *J Nerv Ment Dis* 186:24–34.

Ketterlinus RD, Lamb ME, Nitz K, Elster AB (1992) Adolescent nonsexual and sex-related problem behavior. *J Adolesc Res* 7:431–456.

Koehoe NC, Gutheil TG (1994) Neglect of religious issues in scale-based assessment of suicidal patients. *Hosp Community Psychiatry* 45:366–369.

Koniak-Griffin D, Lominska S, Brecht M (1993) Social support during adolescent pregnancy. *J Adolesc* 16:43–56.

Koyle P, Jensen L, Olsen J, Cundick B (1989) Comparison of sexual behavior among adolescents having an early, middle, and late first intercourse experience. *Youth and Society* 20:461–475.

Larson DB, Donahue MJ, Lyons JS, Benson PL, Pattison M, Worthington EL, Blazer DG (1989) Religious affiliations in mental health research samples as compared with national samples. *J Nerv Ment Dis* 177:109–111.

Larson DB, Pattison EM, Blazer DG, Omran AR, Kaplan BH (1986) Systematic analysis of research variables in four major psychiatric journals. *Am J Psychiatry* 143:329–334.

Larson DB, Swyers JP, McCullough ME (1998) *Scientific research on spirituality and religion.* Rockville, MD: National Institute for Healthcare Research.

Lester D (1991) Social correlates of youth suicide rates in the United States. *Adolescence* 26:55–58.

Levin JS, Chatters LM, Taylor RJ (1995). Religious effects on health status and life satisfaction among black Americans. *J Gerontol* 50B:S154–S163.

Levin JS, Markides KS, Ray LA (1996) Religious attendance and psychological well-being in Mexican Americans. *The Gerontologist* 36:454–463.

Levinson RA, Jaccard J, Beamer L (1995) Older adolescents' engagement in casual sex. *J Youth Adolesc* 24:349–364.

McIntosh DN, Silver RC, Wortman CB (1993) Religious role in adjustment to a negative life event. *J Pers Soc Psychol* 65:812–821.

Murry VM (1995) An ecological analysis of pregnancy resolution decisions among African American and Hispanic adolescent females. *Youth and Society* 26:325–350.

Murry VM (1996) An ecological analysis of coital timing among middle-class African American adolescent females. *J Adolesc Res* 11:261–279.

Murstein BI, Mercy T (1994) Sex, drugs, relationships, contraception, and fear of disease on a college campus over 17 years. *Adolescence* 29:303–322.

National Center for Health Statistics (1993) *Vital statistics report.* Hyattsvile, MD: Author.

Needleman J, Wessely S, Lewis G (1998) Suicide acceptability in African and White Americans: The role of religion. *J Nerv Ment Dis* 186:12–16.

Pargament KI (1997) *The psychology of religion and coping: Theory, research, practice.* New York: Guilford Press.

Politics of the professoriate. (1991, July–August). *The Public Perspective*, pp 86–87.

Rubin RH, Billingsley A, Caldwell CH (1994) The role of the black church in working with black adolescent. *Adolescence* 29:251–266.

Rule WR, Gandy GL (1994) A thirteen-year comparison in patterns of attitudes toward counseling. *Adolescence* 29:575–589.

Sansone RA, Khatain K, Rodenhauser P (1990) The role of religion in psychiatric education: A national survey. *Academic Psychiatry* 14:34–38.

Schindler F, Berren MR, Hannah MT, Beigel A, Santiago JM (1987) How the public perceives psychiatrists, psychologists, nonpsychiatric physicians, and members of the clergy. *Prof Psychol Res Pract* 18:371–376.

Shafranske EP, Malony HN (1990) Clinical psychologists' religious and spiritual orientation and their practice of psychotherapy. *Psychotherapy* 27:72–78.

Sheehan W, Kroll J (1990) Psychiatric patients belief in general health factors and sin as causes of illness. *Am J Psychiatry* 147:112–113.

Sherrill KA. Larson DB, Greenwold M (1993) Is religion taboo in gerontology? *Am J Geriatr Psychiatry* 1:109–117.

Spilka B, Hood RW, Gorsuch RL (1985) *The psychology of religion.* Englewood, NJ: Prentice-Hall.

Stein D, Witztum E, Brom D, DeNour AK, Elizur A (1992) The association between adolescents' attitudes toward suicide and their psychosocial background and suicidal tendencies. *Adolescence* 27:949–959.

Studer M, Thornton A, (1987) Adolescent religiosity and contraceptive usage. *J Marriage Family* 49:117–128.

United States Department of Labor (1998) *Occupational outlook handbook: United States Department of Labor.* Washington, DC: Bureau of Labor Statistics.

Wasman M, Corradi RB, Clemens NA (1979) In-depth continuing education for clergy in mental health. *Pastoral Psychol* 27:251–259.

Weaver AJ (1995) Has there been a failure to prepare and support parish-based clergy in their role as front-line community mental health workers? *J Pastoral Care* 49:129–147.

Weaver AJ, Koenig HG (1996) Elderly suicide, mental health professionals and the clergy. *Death Stud* 20:495–508.

Weaver AJ, Samford J, Kline AE, Lucas LA, Larson DB, Koenig HG (1997) What do psychologists know about working with the clergy? *Prof Psychol Res Pract* 28:471–474.

Weaver AJ, Flannelly L, Flannelly K, Koenig HG, Larson DB (1998a) A systematic review of research on religion in three major mental health nursing journals: 1991–1995, *Issues Ment Health Nurs* 19:263–276.

Weaver AJ, Kline AE, Samford J, Lucas LA, Larson DB, Gorsuch R (1998b) Is religion taboo in psychology? *J Psychol Christianity* 17:222–234.

Weaver AJ, Samford J, Larson DB, Lucas LA, Koenig HG, Patrick V (1998c) A systematic analysis of research on religious variables in four major psychiatric journals: 1991–1994. *J Nerv Ment Dis* 186:187–190.

Weaver AJ, Preston JD, Jerome LW (1999) *Counseling troubled teens and their families: A handbook for clergy and youth workers.* Nashville, TN: Abingdon Press.

Weinrich S, Hardin SB, Johnson M (1990) Nurses response to hurricane Hugo: Victims' disaster stress. *Arch Psychiatr Nurs* 4:195–205.

White SD, DeBlassie RR (1992) Adolescent sexual behavior. *Adolescence* 27:183–191.

Wright LS, Frost CJ, Wisecarver SJ (1993). Church attendance, meaningfulness of religion, and depression symptomatology among adolescents. *J Youth Adolesc* 22:559–568.

Zeidner M (1993) Coping with disaster. *J Youth Adolesc* 22:89–108.